FACT SHEET

Power Mobility Device Regulation

Today's Action: The Centers for Medicare & Medicaid Services (CMS) is issuing an interim final rule with comment period that will implement provisions in the Medicare Modernization Act (MMA) affecting power operated vehicles (or scooters) and power wheelchairs. The interim final rule also describes the clinical documentation that must be submitted along with a written prescription before a supplier may deliver power mobility equipment to a beneficiary.

This interim final rule is part of a comprehensive overhaul of Medicare policies affecting power mobility devices (PMD) that encompasses coverage, prescribing, coding, payment and claims documentation for these devices. The goal is to ensure that beneficiaries who need assistance with mobility have access to appropriate technologies, and that Medicare pays appropriately for these devices.

Background: Over the past two years, CMS has focused significant attention on how power wheelchairs and power scooters are covered and paid for by the Medicare program. The initial emphasis, growing out of a dramatic rise in claims for the most sophisticated and expensive kind of power wheelchair, was on curbing fraud and abuse by certain unscrupulous suppliers of these devices.

As this problem was brought under control, CMS embarked on a comprehensive review of how Medicare covers and pays for PMD. In a three-pronged initiative announced in April 2004, CMS spelled out plans (1) to review the coverage criteria for PMD; (2) to develop new codes for PMD that would allow CMS to tailor payment rates for PMD to the particular features of the specific equipment supplied; and (3) to develop and implement quality standards for suppliers of PMD.

Through its National Coverage Determination (NCD) process, CMS has recently issued new function-based criteria for PMD to replace the historical "bed or chair-confined" standard, which had restricted access to needed equipment for some beneficiaries. CMS believes the new criteria, based on expert medical consensus, will help physicians and treating practitioners, as well as suppliers, to better meet patient needs.

In this interim final rule, CMS establishes new procedures for prescribing, supplying and billing for PMD, in light of the new coverage criteria and MMA provisions affecting these devices. The MMA provisions expanded the types of health professionals who may order certain types of PMD, and required a face-to-face examination of the patient by the prescribing physician or treating practitioner (such as a physician's assistant, nurse practitioner, or clinical nurse specialist) before PMD may be prescribed.

-More-

Specifics Of The New Regulation: This interim final rule clarifies the responsibilities of physicians and other treating practitioners, as well as suppliers of PMDs, to ensure that each beneficiary receives the type of power wheelchair or power scooter most suited to his or her needs. It also implements the MMA provision eliminating a requirement that a power scooter could only be prescribed by a specialist in physical medicine, orthopedic surgery, neurology or rheumatology. This new regulation will be effective October 25.

This new process provides new opportunities for a broader range of health professionals to be more actively involved in deciding whether a beneficiary needs a PMD, and, if so, the appropriate type of PMD. It will also give physicians, other treating practitioners, and suppliers greater certainty regarding Medicare payment, by providing more extensive guidance for how PMD claims can be supported by well-documented findings by physicians and other treating practitioners.

Further, the new process includes specific payments to physicians and other treating practitioners for providing clinically complete documentation, and it eliminates the burden for physicians and other treating practitioners to provide potentially duplicative information on multiple forms. In particular, the interim final rule eliminates the need for a physician or other treating practitioner to complete and sign a Certificate of Medical Necessity (CMN) to accompany the order for a PMD. CMS's experience has been that the CMN did not work as well as originally hoped, because important functional details in the medical record have frequently not been included in the CMN. The beneficiary's physician or treating practitioner is in the best position to evaluate and document the beneficiary's clinical condition and medical needs, and good medical practice requires that this evaluation be adequately documented. Thus, to minimize the documentation requirements for providers while assuring that documentation is adequate, physicians and treating practitioners will now submit copies of relevant existing documentation from the beneficiary's medical record, rather than having to transcribe medical record information onto a separate form such as a CMN.

Physicians' And Other Treating Practitioners' Role And Responsibilities:

- *Face-to-face examination:* The MMA requires as a condition for payment for PMD that the equipment be prescribed by a physician or other treating practitioner who has conducted a face-to-face examination of the beneficiary. A beneficiary who has been recently hospitalized will not need a separate face-to-face examination, as long as the PMD is prescribed within 30 days of the date of discharge by the physician or treating practitioner who performed the face-to-face examination during the hospital stay. The face-to-face examination requirement does not apply when only accessories for PMDs are being ordered.

When discussing options for PMD with beneficiaries, physicians and other treating practitioners should be aware of the coverage policies that will be applied to the claim. These policies are outlined in the NCD. They include the steps for evaluating whether a beneficiary needs assistance with mobility, and if so, the type of technology that is most appropriate. The analytical framework for the evaluation can be viewed on our PMD website at *www.cms.hhs.gov/coverage/wheelchairs.asp*

- *Written prescription:* The physician or treating practitioner must submit a written prescription for the PMD to the supplier. This prescription must be received by the supplier within 30 days of the face-to-face evaluation, or in the case of a recently hospitalized beneficiary, with 30 days of discharge from the hospital. The written prescription must include the beneficiary's name, the date of the face-to-face examination, the diagnoses and conditions that support the claim for the PMD, a description of the specific type of PMD required, and the expected length of time the beneficiary will need the equipment. The prescription must be signed by the physician or treating practitioner and dated.

- *Supporting documentation:* The physician or treating practitioner who performed the face-to-face examination must submit to the DME supplier the prescription accompanied by supporting documentation of the beneficiary's need for the PMD in the home (a standard required by statute for all durable medical equipment). The supporting documentation will include pertinent parts of the medical record that clearly support the medical necessity for the PMD in the beneficiary's home, which may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans. It may also include information from other examinations, as well as relevant reports from other consultants and practitioners.

  This combination of a written prescription and supporting clinical information will replace the Certificate of Medical Necessity (CMN) that was previously required in ordering such equipment. In addition to the analytical framework on PMD Website, CMS has also posted the regulation, this Fact Sheet which summarizes the changes and new requirements, and a list of Questions and Answers to help in answering most of the questions physicians and treating practitioners may have. CMS will also have a Medlearn Matters article on its website within the next 30days to provide further guidance about implementation.

- *Billing and payment:* The physician or treating practitioner will bill Medicare under the Physician Fee Schedule for the appropriate level of office or hospital visit for the face-to-face examination. In addition, as noted above, CMS is establishing an add-on G code for

- submission with the claim for the face-to-face examination that will allow the physician or treating practitioner to be paid for the work and resources involved in compiling and submitting the required documentation from the medical record. The payment amount for this new G code for 2005 is $21.60, adjusted by the geographic area where the service is provided.

DME Supplier's Role And Responsibilities:

Prior to dispensing a PMD, the DME supplier must have received the written prescription and supporting documentation from the physician or treating practitioner who performed the face-to-face examination. The supplier must identify the specific type of PMD to fill the prescription, and must ensure that the specific item of PMD can be used by the beneficiary in the home (for example, that the PMD will not be too large to go through doorways between rooms).

Implementation And Outreach: Soon after the interim final rule is released, CMS will initiate a broad educational effort, including Open Door Forums and a *MedLearn Matters* article for physicians and treating practitioners, describing their critical role and responsibilities in prescribing power mobility equipment. CMS will also issue implementing instructions to the Durable Medical Equipment Regional Contractors (DMERCs) that are responsible for processing claims for PMD to promote consistent claims processing under the interim final rule and the National Coverage Determination for Mobility Assistive Equipment.

In turn, the DMERCs will issue a series of articles, as well as a local coverage determination (identical across all four DMERCs) providing guidance to suppliers on the types of documentation from the beneficiary's medical record that will be needed to establish the medical necessity of the prescribed equipment. Under the function-based criteria established by the NCD, an appropriate coverage determination for these products may include consideration of the patient's medical history, elements of a physical assessment such as strength and range of motion, a functional needs assessment, and an evaluation of other available devices, as documented in the medical record. This guidance will be available to physicians, treating practitioners, and suppliers prior to the effective date.

While physicians, treating practitioners, and suppliers become acclimated to their new roles and responsibilities, the DMERCs will carefully monitor billing trends to identify extraordinary situations where further intervention is warranted to ensure that claims are submitted accurately and that coverage decisions are appropriate.

CMS believes this interim final rule and implementing efforts will increase claims processing consistency, while ensuring that beneficiaries receive the most clinically appropriate mobility equipment and that suppliers are not unfairly penalized by lack of medical documentation. In sum, all stakeholders — physicians, treating practitioners, patients, and

suppliers — will benefit from this comprehensive set of reforms. CMS is publishing this approach as an interim final rule, and is soliciting constructive comments to further the goals of appropriate clinical evaluations to go along with the new functional criteria, and clear guidance with minimum additional paperwork burden for physicians, treating practitioners, and suppliers.

# # #

APPENDIX

DOCUMENTING MEDICAL NECESSITY
POINTERS FOR PHYSICIANS AND OTHER TREATING PRACTITIONERS

When prescribing a power wheelchair or power scooter the physician or other treating practitioner must provide the supplier with documentation of the medical necessity of the device prescribed. This should include pertinent parts from the documentation of the beneficiary's face-to-face evaluation, such as the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans.

The physician or treating practitioner should select only those parts of the medical record that clearly demonstrate medically necessity for the PMD.

The parts of the medical record selected should be sufficient to:

- delineate the history of events that led to the request for the PMD;
- identify the mobility deficits to be corrected by the PMD;
- establish that other treatments do not obviate the need for the PMD,
- establish that the beneficiary lives in an environment that supports the use of the PMD: and
- establish that the beneficiary or caregiver is capable of operating the PMD.

In most cases, the information recorded at the face-to-face examination will be sufficient. However, there may be some cases where the physician or treating practitioner has treated a patient for an extended period of time and the information recorded at the face-to-face examination refers to previous notes in the medical record. In this instance, those previous notes would also be needed.

The physician, treating practitioner or supplier that is a HIPAA covered entity should make sure to remove or edit any materials that may be contained within the medical record that are not necessary to support the prescription. For example, a gynecologic report would not be needed in the records submitted for a beneficiary whose clinical need for a PMD is based solely on disability secondary to a stroke.

# # #